Health Education in India: Enhancing British-Indian Co-operation.

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September 1994

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The report, which draws particularly on work in the fields of leprosy and AIDS, notes some of the obstacles there are to western style health education in India. Against this background some suggestions are made as to how we might foster co-operation in the future. Amongst these suggestions two specifically relate to worker education of a type undertaken by Queen Margaret College, details of these courses are given in two Appendices.

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Introduction.

It was a rare and delightful opportunity to be able to have four months exploring current work on health education in India. My thanks to my college for allowing me to go, and to my hosts for such a warm and accommodating reception. Within the field of health education I concentrated on two areas: AIDS and leprosy. Besides illustrating many aspects of health education, these diseases are both associated with complex reactions within our societies, and they also require that health professionals try to help people change their behaviour. Thus they are of central importance to anyone, such as myself, teaching in the area of health education.

My period in India allowed me the opportunity to review the way in which health workers teach, train, instruct and persuade in their daily practice and to reflect on the implications of my observations for the training we give to health workers. The visit also allowed my review to go from 'bottom to top': from the activities of unpaid community health workers, to the work of national co-ordinating bodies. The topic of AIDS had an additional advantage for my explorations; it is still a relatively new area of work in India, and so the organisations involved have not yet grown to be as complex as they are in some older fields.

A short visit, coupled with a lack of knowledge of India, is scarcely a recipe for acuity. I can only offer that it is hard to stand back and regain an overview of our daily work; the visitor just might catch a glimpse of something we can no longer see. The following notes bring together points from observations, discussions and reflections made with the help of many individuals, projects and organisations. All those who so kindly helped me are listed in Appendix 1; and this document is being sent to them all by way of thanks. I believe that the points made here have been fully discussed with Indians in the context of their work. However, as the content is addressed to many people, there will be some readers who would wish for more illustration or argument; naturally I would be very glad to elaborate or discuss any matter further.

In this paper I have taken as read two valuable publications of Voluntary Health Association of India: State of India's Health and Health for All . I also found, as a foreigner, the Tata Institute's book Prevention of AIDS helpful and lucid. The material below is divided into two sections. The first section selects features of Indian society which impinge on health education, and which make the direct application of western style techniques problematic or inappropriate. These points tend to come over as difficulties for the health educator, but they

are only difficulties if you start from a certain perspective. I think it is more helpful to treat them as warnings to us that the job of 'translating' ideas from one culture to another is not simply a matter of language; I have given an example of the point with reference to one well known manual. This first section is therefore necessarily tentative. In contrast the second section suggests three areas where the extension of co-operation between our two countries would seem to promise best reward.

Section One - Obstacles to Western Style Health Education in India.

By health education I mean those efforts which the state, or voluntary organisations, make to help individuals, groups and communities, improve their health status through the provision of information, instruction, training, education, or even persuasion. As a stranger to India I saw health education work which benefited enormously from the intelligence, creativity and industry of the workers involved. The ideas, information and quality of discussions never ceased to be stimulating. But a question, to which I found myself being brought back repeatedly, was the extent to which India had to contend with additional obstacles in her work of promoting health; that is obstacles in addition to the ones we encounter in Britain. In the second section of this paper I will take up the point of India's positive additional resources. Here my concern is the kind of extra burdens that health education encounters. Below seven such additional weights are indicated.

1) The relative power positions of men and women. The position and power of women is central to the effectiveness of health education. This point is well illustrated by the problem of controlling AIDS. Women are more likely to become HIV positive from contact with men, than are men from women. Women may pass it on to their unborn children. It is women who introduce children to appropriate health practices. It is women who provide the first line of defence against disease for their families. Women's power is crucial. The 1991 census returns tell the sad story of how powerless women are in India.

The different situations in each State of India make any generalisation misleading. In certain States women have considerable power, in certain organisations they have taken power, and the fundamental equality assigned to them in the Hindu ethic is patent. This means that good models abound. Nevertheless, in many areas it is not possible for men to initiate health education directly with women in the community; and this same social structure means that too few women come to be trained as health workers; in turn there are then too few women to persuade others to come forward; and so on. Problems of co-education, of women travelling away from their homes, and of women's social deference to the point of view of a man, all conspire against the development of health education.

2) Social hierarchies and structures. People I met within organisations and within communities were very clear about their relative positions in these groups. The distinctions and differences were, to an outsider, subtle, but they serve to give individuals a very exact and very secure place in life. Such security is of great psychological value. Its cost can be in terms of flexibility, response to change, and the way we accept the truth of new ideas.

The AIDS problem provides a good example of the need there may be in health education for a rapid response. Such a response is inhibited: by the niceties of protocol (for example, by spending time giving thanks and praise to individuals rather than exchanging ideas at meetings); by the way such systems channel so much business through high status bottle necks (for example, the way a senior person in an organisation kindly gives time to visitors, or must discuss a detail with which they are less familiar than would be one of their juniors); and, by the way status wins over relevant knowledge and experience (this area, which is crucial for health education, is expanded upon below in point 3). It is as though there is a balance to be struck between giving security to individuals, and allowing a flexible response to changes. In Britain we clearly err in failing to provide sufficient security for individuals; as a visitor to India I sometimes wondered if a price had to be paid for individual security in terms of a lack of flexibility to a new challenge like AIDS.

In health education there is another aspect to the problem of status. The aim of much work is to change behaviour. We change our behaviour thoroughly only when we believe it is in our power to do so. This so called 'self-efficacy' depends on seeing the problem in terms we can understand, and seeing it as our own problem. Being told to do something by someone, however important a figure they are, has no lasting effect. Successful health education requires the health professional to be seen as the aide and assistant to the solution of the problem. Interestingly, here there are direct implications for the way we train health workers. If workers are to engage patients as their aides, then, while students, they must also have been aided by their teachers in the enterprise of their studies. This point links with the one about problem orientation below on page 10.

3) The special status, qualifications and non-medical employment of members of the medical profession. To a non-medical observer technical western medicine in India seems well developed. Knowledge of diseases, prognosis and treatments are encompassing, competent and seem well updated. However, a number of problems arise around medically trained workers. In India, as elsewhere, the medical practitioner is of very high status in the eyes of much of the population. This confers an authoritarian power which is inimical to helping people take responsibility for their own diseases and for changing behaviour. The professional complaint, I often heard, was that patients did not do what they had been told. We tell small children what to do and expect it to be done. The status differential between doctors and patients is often rather similar, but of course patients are mostly adults with their own world views which are equal

in status to those of the doctors; whatever the external social order. The problem has two facets: the way that medical workers misuse the status given to them and emphasise inequality, and the methods of training students which promote knowledge and its use as the basis of good practice, rather than problem solution and negotiation. The British medical establishment has had very similar problems and only in the last generation has sought to provide a more relevant education for students.

The status of medical workers in India is also bound up with Westernisation. Western techniques and technology are given a priority which often appears to be at odds with the health problems facing India. Many workers did not seem to value India's diversity of traditional approaches to health, although VHAI, and its excellent work, show how rich the blending of traditions can be. A twist to the status problem, and Westernisation, is the demarcation between those who are 'qualified' and those who are 'quacks'. The system of degrees and conferments in India has not managed to separate, in the public eye, the distinction between those with relevant training and those without it. This seems partly a technical problem of feasibility, or appropriateness, in establishing a legal register of qualified persons, and partly a wish of the less well qualified ('quacks') to be able to share in some of the very large rewards that medical practitioners can earn. I did see excellent examples of trained physicians working in partnership with those less well trained, lending them support and information, so that the 'quack' could direct more serious illnesses to the medical doctor. But this was exceptional; too often there is no such harmony as status, and financial gain, rule. These difficulties are increasingly affecting work with AIDS.

A further problem connected with medical workers is the way that medicine has attracted many able young people, providing them with a means to a good, and socially valuable, livelihood; it has been a key way of gaining high status and of 'getting on'. This means that many projects and organisations are headed by people with medical qualifications chosen for their social eminence. Some of these people are naturally able administrators, managers, leaders and educators. But of course most of us are not naturally able at any of these things, we have to learn; and medicine does not help us learn how to manage, or how to organize, or how to educate. Medical practitioners are no better or worse at any of these things than any other interested person. Curiously medical workers often believe that while their own training made them good doctors, no analogous training would make them good managers, educators, etc. This blindness to other professions did show in a number of projects and organisations I visited. As a result they were not always as efficiently managed as they might have been, the health education being provided was not as good as it might be and the understanding of behavioural change was sometimes limited. This point is continued in the note on management on page 9 below.

There is another allied problem here which is delicate for a foreigner to raise. It is the appearance that, in certain cases, some medical workers may not be so

concerned with their patients' future well being as with the personal rewards they receive themselves. Of course this is a problem in every country and is presumably no different in India. What is different, is the large number of stories I was told about professionals' own self interest. Examples include: failure to attend conferences on AIDS as it conferred no status or financial reward; applications for grant money in AIDS related work by individuals who appeared to have nothing to offer the problem, but a great deal to gain from receipt of the position and money; and the appointment of senior workers without proper procedures that would have ensured that the best person was found for that job.

This whole set of problems surrounding medical workers does seem to make health education harder. For example, projects and organisations concerned with AIDS need leadership which can co-ordinate a range of resources, be they medical, behavioural, educational, social, or that provided by 'quacks'. The high status of a single profession works against this process. The fact based approach to learning, which is used in much medical education, also hinders problem solution and flexibility of developments. Added to this is an over enthusiasm for western approaches to problems; approaches which are as yet unproved in India, and which narrow the opportunities for locally appropriate solutions.

4) The way certain government bureaucracies are perceived as performing poorly. The myth of the poorly performing Indian bureaucracy was presented to me by Indians everywhere I went. Such beliefs, whether based in fact or not, are in themselves a handicap. Able workers, especially the young, seem to seek to work for independent organisations such as the NGOs to escape the stagnation they foresee in working for the government. If this does happen, it is sad that the official offices should be deprived of enthusiastic workers. This theme is continued directly below in point 5. The stories of slow decision-making and mismanagement of money, by official bodies, also seem universal, and expressed the keen frustration of those telling them. Again, whatever the facts of the matter, the myths in themselves have effects which make getting on with health education that much harder.

5) The relationship between government and non-government organisations. Because of the problems that the NGOs perceive as appertaining to government-based bureaucracies, many of those doing the most creative, sound and fruitful work wish to keep their distance from these government bureaucracies; indeed to the extent, in some cases, that they do not seek government funds because these are seen as more of an impediment, than an aid to good work. There are a number of effects of this distancing. One of the results is the fragmentation of effort which leaves the hundreds of AIDS NGOs in ignorance of one anothers' work, and at the same time strongly resistant to being drawn into any bureaucratic framework. This means that work on AIDS control and prevention, which is of the highest quality by world standards, is too often poorly disseminated.

The picture I gained in India was one of small, highly successful and independent projects which have no prospect of being generalised. Indeed, some team members I have talked to are sceptical as to the generalisability of their work, for the very factors that make for the success of the truck drivers' project at ARFI, or the quality of the broadcasts by Chitrabani, or the techniques of training health workers in Apnalya, are the individual creativity and integrity of the workers, not any generalisable formulae. Nevertheless if the most promising work is going on out in these NGOs, it presumably must be all our wishes that the work be fostered and strengthened. The problem with such myths is that it takes slow and painstaking work to dispel them. I did see fine models of efficient and supportive management free of tales of corruption, and well respected, in government offices, and we have continuously to remind ourselves of such good models and treat them as the norm. There are some general points made about the training of workers, and in particular managers, in the second section of this paper which apply equally to government and non-governmental organisations. But, more specifically, there are tasks for a central body that would increase confidence: the provision of digestible, accessible, and up to date information, the setting up of open fora for the exchange of ideas, and the provision of unfettered technical support are all examples of ways in which the central authority can increase trust.

6) The rich diversity of languages and cultures. India's rich diversity is widely acknowledged. No one denies the need for translation and 're-standardisation' in health education work, be it of language or social norms. I was, however, struck by the gap there appeared to be between the general acceptance of the need for such translation, and the feelings of those involved in service provision who continuously seemed to suffer from being on the receiving end of materials and ideas which were not tailored to their specific social/cultural/linguistic needs. Somehow the good intentions do not work out. One noticeable example is how the best set of language translations of AIDS related material comes not from Delhi, but from Sol publications in Bombay, and that is simply into the main 13 languages. Service providers are never funded to undertake the local normalisation of materials, but this is one of the real costs of India's rich diversity, and it was quite often Indians from central organisations who seemed rather unconscious of this diversity. I suppose as a foreigner one is sensitive to such matters - I expect I would be clumsy about the diversity in my own country.

There is a specific training problem connected to this diversity which I often met. It is the sight of a class in which at least two of the students had no language in common. This was as true of institutions which explicitly catered for students from all India as it was at more local centres. Often it was as though people in, maybe distant, administrative offices of an organisation did not quite appreciate that saying that English or Hindi would be the medium of study did not in itself guarantee the fluency of students in these languages.

The teachers are then left to pick up the pieces. The outcome often appeared to be wasteful of resources.

7) (For the specific issues of AIDS) The relative reticence of Indians on sexual matters. All the projects I visited noted the poor level of understanding of sexual matters among their client groups. Sex education is not common, and young people do not, in general, have access to a thorough, clear and balanced view of human sexuality. This ignorance becomes the base on which AIDS workers must teach. So discussion of AIDS has to be preceded by much ground work, which again absorbs additional resources. Connected to the lack of open discussion of sexual matters are misleading myths and beliefs about sexuality. For example, two which have a direct affect on AIDS education are: the notion of 'good' and 'bad' women; and the idea that masturbation is harmful. The same reticence also means that evidence about sexual behaviour is poor. What evidence we have points to behaviour which conflicts with safe sex messages. For example: a very high incidence of the use of prostitutes; low incidence of masturbation; clandestine, furtive, and very rapid sexual acts.

Another aspect to this problem, which is a little amusing to a western eye, is the fact that many of those who engage in sex education as a basis for AIDS education are themselves not as well versed in sexual matters as their western counterparts might be. It was clear, for example, that few workers, whom I heard talking about the advantages of the use of condoms, had actually used condoms themselves. This meant that as educators they were at a clear disadvantage compared with their British counterparts.

Reticence about sexuality is not just a simple matter cured by education. As in Britain there is a hypocrisy that surrounds sexuality and which can prevent work from even being undertaken. Many politicians and some authorities have still to be convinced that Indian sexuality is not in fact any different from any other human sexuality.

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These are seven points which I repeatedly encountered in my travels from Delhi to Trivandrum. They become problems if it is appropriate to apply health education in India as it is applied in Britain - it may or may not be so. The complexity of some of these areas is such that to label them problems is disfiguringly reductionist. I propose them more as warnings for our co-operation on matters of health education. Sometimes we need such warnings; let me give one illustration of this need by referring to a book, which I think is most excellent and useful.

The WHO manual: AIDS Home Care Handbook I thoroughly recommend as a source book for those working in health education in the AIDS care field. But if we check it against the list I have given above, do we not feel its inadequacies? It leaves all the complex problems of social translation unattended. Project

workers do not have the time, energy, or resources to do the kind of translating that is necessary and work out the implications of the books' contents. There will be problems of implementation due to any of my seven points, and these problems will vary from State to State, and even from District to District; and there will be many other points that a local worker would add to my list. Just from that list, however, such questions as these might arise: what part can women decently play in care for non-family members?; what of the problems of giving care to someone of differing social status?; what of the influence of control of care by inappropriately trained medical personnel?; how can the distribution of the handbook by a state organisation be done through an NGO when it wishes no contact with the state?; how do you get round the simple fact that the key workers involved do not read any of the languages in which the book is printed?; how can you give instructions like "Couples should talk about sex" in a society where there is no history of such talk? That is a good book; there are plenty less well thought out.

On my visit I often saw good materials, like that book, being laid aside because the sorts of problems I raised in the last paragraph are greater than any possible benefits. Extending British-Indian co-operation in health education must include helping address such 'problems' and 'translations'. This section has dealt with general cultural differences that strike a Westerner for the implications they have for health education in India. We can call these implications obstacles and try to overcome them, but that is a particular construction. They are at any rate challenges which present opportunities and possibilities which may not have been thought of in health education as it is practised in Britain. I believe this foregoing section relates very simply to British Indian co-operation. In all our dealings over health education we have to take these points on board; points which cost money and take energy to address. During my visit it was rare to see sufficient account being taken of these factors.

Section Two - Action to Enhance Co-operation on Health Education.

The factors presented in the last section, which impinge on health promotion, are not ones for specific action. All the work we do in either Britain or India must seek to promote the equal status of women, must recognise the diversity of cultures in our countries, and should aim to reduce the burdens of bureaucracy. Rather, they are points which we must remember in our exchanges, teaching and writing. However, there are aspects of health education where specific action seems more appropriate. Such actions, which are often channeled through the British Council, seem widely appreciated and the scarce resources well spent. The impression I gained from British Council officials in India was that policy was evolving, as it always must, and that now was a good time to make suggestions about its future direction.

And so this section makes some specific suggestions for co-operation on matters relating to health education. Below three areas are discussed: liaison between parallel organisations and projects, in the two countries; the exchange

of certain skills; and the offering of support to India in furthering its own advantages.

1) Liaison between British and Indian Organisations. There are many ways in which we can exchange ideas between our two countries. The British Council is active in promoting these exchanges. The linking of academic institutions, supporting student study in Britain, and funding visits to India by individuals are all valuable services in the cause of co-operation. There are advantages and disadvantages to all such links. One type of link I did not meet was the pairing of non-academic organisations or projects; for example providing support for an NGO, like the West Bengal Voluntary Health Association, in finding a sister organisation in Britain with whom a partnership could be established. Such a link would then serve as the conduit for visits and studentships, so obviating some of the problems with, for example, experts from Britain who are unable to translate their ideas to fit the Indian context, or with students whose British education fails to benefit more than the individual. This type of twinning was suggested to me by a number of organisations. The benefits were seen in terms of exchange, information, and potential accreditation and stimulation for workers. But projects in India have no way of building such bridges alone, they need the pro-active help of an organisation like the British Council to set up the links with appropriate bodies.

2) Dissemination of Western Skills. Despite being a teacher and trainer I have no strong beliefs about the effectiveness of the processes with which I am involved. We learn best by doing the job alongside someone who does it very well. But training is fashionable, and if we believe that good doctors can be made by their training, then we should also acknowledge that good managers, educators and communicators can be trained as well. Western style health education requires a range of skills some of which, at this particular time, may be better developed in Britain than they are in India. Below I have selected five examples where I was told that development of skills could be beneficial, and where I also observed the scope for such development.

a) Processes of management. From a western perspective it did seem that the quality of management of organisations I visited was not as high as might be expected given the great resources of creativity and intelligence that are clearly in evidence amongst the workers wherever I went. It may be that notions of effective management do not transpose sensibly between our two societies. The problems I saw of managers swamped by trivial decisions and responsibilities, by failures of prioritization and selection, and by failures of providing adequate support for staff, may arise as part of a wish by workers not to be burdened by management worries, and a wish to keep patriarchal organisations as a protection to the workers. Certainly, questions of efficient practice must be placed in their social context. However, at present management practice in nearly every project and organisation I visited used financial resources poorly. I was not led to believe that alternatives had been examined and rejected, and I was not shown that the social context really demanded these

apparent inefficiencies. I believe rather this lack of training is connected with point 3 in the previous section on medical personnel. Appointments of senior people are sometimes made, not because the person has the skills or experience for the job, but for other reasons.

It would seem helpful if more people amongst senior management in the field of health education were offered western management training to see if they felt it was of any value to them. Even if it did no more than provide a breathing space for managers to reflect on their own practice, it might be useful. Queen Margaret College has a number of short courses related to the needs of such health professionals, some further details are given in Appendix 2.

b) **The Understanding of behavioural change**. Our understanding of human behavioural change is still tentative, we have a great deal to learn. But we do know processes which are not effective in bringing about change, and others which may be of some value. The health educator needs to share in the experience we have gained, or past mistakes may be repeated. I did see quite senior people in health education who were possibly unsure of basic distinctions, as, for example, between the notion of giving information on the one hand, and education on the other (as in the phrase Information, Education and Communication), or between the concept of attitude and that of behaviour. Again it might be that effectiveness could be increased if more training in these areas was available. This is my own special area of interest and since my return from India I have been developing a set of postgraduate courses that are intended to be of value to workers in health education from South Asia, some details of which are given in Appendix 3.

c) A problem solving orientation The first section of this paper, on obstacles to health education, illustrates how necessary it is for health workers to have a problem solving orientation to their work. As a visitor I did wonder if some of the health worker training lacked this orientation. Fact based learning is useful for classification and aspects of diagnosis, but not much help in developing problem solving skills. To help us solve problems, whether it be the problem of coping with 200 patients each morning, or the problem of standing all morning on an anaesthetic foot while cutting hair, we have to see the problem as a challenge which we will solve. Instilling this attitude of mind can turn the whole process of training students into a much more enjoyable experience for all concerned. It may be that some trainers and teachers have not had enough of this pleasure, and when it comes to sharing our skills we should, therefore, ensure that everyone has more of it!

d) Communication skills. The importance of two specific skills was repeatedly pointed out to me: listening and sympathising. The reasons why we are

unable to listen or sympathise are many. (Having 200 patients waiting to be seen is not a bad excuse for their lack!) Health education requires, for many reasons, a facility in both of these. We can be helped to be better listeners, and we can be helped to express our sympathy appropriately. I saw workers being trained in these areas by progressive staff, and in progressive projects, but such training was not common. Ways should be found to support and promote those already skilled in this type of training.

e) **Skills of monitoring and evaluation.** Monitoring and evaluation are skills continuously exercised by all good managers and teachers in their endeavours to improve effectiveness and efficiency. Increasingly we are also asked to provide evaluation in a documented and official manner. Good evaluations are worth a great deal, for however splendid a project might be, its splendour is enhanced if others have access to learning from its strengths and weaknesses. In India I saw excellent examples of insightful evaluation of projects, notably again from VHAI. However I also saw, and not least at a national level, documents claiming to be evaluations, but which gave the appearance of being aimed at reassuring senior managers, rather than improving future performance. I did meet quite a number of senior workers who were a little rusty on notions of setting objectives, or monitoring processes. In the light of the pressure on many organisations to produce evaluations of an internationally acceptable standard, our experience of developing evaluation techniques could be more widely shared.

These five areas provide specific examples of training which is available in Britain, and could be tailored to Indian needs; that is, of course, if it is felt to be appropriate for India to take on the style of health education that we have adopted in Britain.

3) Developing advantages. From a western perspective, it would seem that India has certain disadvantages in health education as outlined in the last section. My reaction to this is two-fold. Firstly, people seem far too willing to accept western ideas and techniques, in particular to accept that western health education could and should be imported, more or less as it stands. Personally I am not convinced it can, or should be, so easily accepted. Secondly, I met a tendency to concentrate on 'disadvantages'. Steps are taken to re-educate doctors, or to reduce status distinctions, or to involve women in decision making, or to improve sex education: and this is all surely well and good. But what about looking the other way? What are India's strengths for health education? This was not a question which came easily into discussions - it was, I think, always novel to those hearing it. I wish simply to suggest four important strengths that I believe India has for the promotion of health; strengths I did not hear discussed except at my instigation.

a) **The ability of charismatic figures to lead large sections of the population over matters of important principle.** India has a history rich with charismatic figures. Repeatedly people appear who seem to act from the highest of motives to help fight oppression and mis-government, and who, at the same time, promote the best of human moral values. We have a lack of such figures in Britain. India has charismatic leaders and people who are willing to listen to them which, from a health education point of view, seems a great advantage. I wonder to what extent those concerned with health education have tried to identify and work with such leaders, to understand how their charisma works, and to see if there are ways in which it might be of use in the face of present problems?

b) **The ability of women's movements to be formed, gain ground and change the law in very short periods.** Whatever the generally poor status of women in terms of social power, it does seem that on certain occasions very strong movements flourish. Obvious examples include the tree hugging of women protecting their environment in North India and the ban on alcohol sales in Andrea Pradesh villages in South India. Neither of these movements were in states where women's voices are thought to be strong. Many features of the alcohol sale ban are fascinating. The speed of the whole process, the anti-political nature of it (the women were very clearly only concerned with their own villages), and the fact that it attacked a male preserve, are all intriguing pointers. Nowhere did I meet workers in health education trying to understand the principles of these powerful movements, principles which might well have bearing on, for example, the AIDS problem.

c) **The Hindu ethic of respect and equality between living beings, and the family and social values which stem from that ethic.** One of the clearest contrasts between Indian and British society is the place that a systematic code of ethics has in the society. In India religion, in a broad sense of the word, permeates every conversation and event. To an outsider this would appear to be an enormous advantage in the promotion of health, for apposite Hindu stories and parables abound and are known to all. Environmentalists are already making use of traditional beliefs in their work of protection. Surely there must be a rich fund that could be used to help society defend itself against the attack of AIDS? In Britain the puritan Christian ethic seems to have rather worked against the control of AIDS; much Hindu literature is not so puritanical. I did not hear workers speaking of dialogues with Hindu priests to explore the joint work that they might do together.

d) **A wealth of human energy and talent that responds well to creative leadership.** Such a wealth that I can only assume that somewhere in India any points I might make have already been fully debated and explored.

While it is important to address weaknesses, it is also important to 'play to our strengths'. Understanding strengths and the ways that we can use them was not a strategy I saw being adopted. I wonder why? In the burgeoning field of AIDS work in India, I only met two teachers (at the Tata Institute in Bombay), who seemed to be thinking along these lines. Exploring ways of exploiting strengths should not be expensive and might bring quick results, whereas re-educating doctors, or encouraging women to more public participation, may take generations.

Conclusion.

The points made about obstacles to health education, and areas for enhancing co-operation, are largely based on observation of leprosy and AIDS work. However, from my discussions with a range of organisations I believe these points may be more generally true of health education. They are clearly points made by me with one eye on our education and training systems, for this is my particular area of interest. And I would stress that it is indeed a particular perspective. More widely, exciting programmes and initiatives in health work abound in India, some stem from national agencies, some from foreign institutions (such as the British Councils programme of AIDS work in West Bengal) and some from the creative NGOs that have already been mentioned (Chitibani, Apnalya, and ARFI). Nothing that has been said in this paper is meant to subtract from our expectations from such sound work. Rather as these programmes mature, the place of health education and training becomes more central. The points I have made are intended as prompts in that context. Health education is a key area in any developmental health work. It is a fascinating area where Britain and India have so much to learn from, and give to, each other. I do hope I can be part of our increasing co-operation.

Appendix 1 - Individuals and organisations who contributed to the ideas in this paper.

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Appendix 2 - Management in Health Care.

This course for managers in health care has been designed for health workers who come from a variety of cultural backgrounds. The course is in two parts. Each part is equivalent to a postgraduate level module in the Queen Margaret College scheme, that is twelve such modules make up a masters degree. Successful completion of part one is a precondition for starting the second part. It is intended that the course be available through different delivery patterns. These include an intensive two week period in the summer, with appropriate preparatory and succeeding work, and the possibility of intensive local delivery in other countries.

Part I - Principles of Human Resource Management as Applied to Health Care. This part of the course is designed for those who have responsibilities towards other managers or staff in the health professions. It examines human resource management, exploring major developments from the traditional human relations approach developed in the sixties, through to critical consideration of recent fashions in management. Principles drawn from psychological and sociological traditions are shown to underlie many aspects of modern work in health management.

1	Personal Development	Self management. (e.g. Schoen's work on reflective practice). Personal development plans in health care work: e.g. Boydell and Pedler (Self-development), Woodcock and Francis ('Blockages'). Managing self in order to manage others - theories of learning and management practice (Argyris).
2	Managing Competently	Managing in health and social care - inter-agency co-operation. Problems of interprofessional language and cultures. The contribution of Human Resource Management Theory (McGregor) in the context of modern health organisations: Taylorism to Contingency Theory. Models of management: Mintzberg, 'Change Masters', 'Gurus' of the 90's, empowerment.
3	Managing the Selection and Development of Staff	Equality of opportunity and the recognition of diversity within health work - problems of countering discriminatory practices (e.g. sexism, racism) in the workplace. Theories of recruitment and selection. The use of equal opportunities selection procedures, skills involved in producing job analyses, the practice of interviewing and the science of selection in health care. Staff development, strategies of performance appraisal. The implementation and evaluation of appraisal schemes. Feedback and support mechanisms, including mentoring.

Continued

	(Continuation)	**Part I - Principles of Human Resource Management.**
4	Manager-Employee Relationships	Power relationships in the work situation. Unitary, radical and pluralist perspectives on health organisations. Managing effectively in conflict situations. Sources of interpersonal conflict; eg change, role conflict, resourcing, inequality. Models for handling conflict such as: Conflict Management (Thomas), Conflict Resolution (Bertinasco), and Assertive/Co-operative (Whetter and Cameron). Personnel management, organised workers' unions; negotiating and bargaining in the context of health care.
5	Teamwork	The formation of teams in the workplace: from Bion to Belbin. Group size and effectiveness; Belbins typology for the recognition of roles. Use of Leavitt's communication network.

Part II - Managing the Organisation. This part of the course enables the use of skills, expertise and theory developed in Part I to be translated directly into the changing organisation. This second part of the course can, therefore, be regarded as the macro view of organisations, while Part I presented the micro view.

1	Managing Change	Causes, consequences and challenges of organisational change. Recent western need for increased effectiveness in health delivery. 'Death of Bureaucracy' (Bennis) and the creation of 'adaptive structures'. 'Fast, flat, flexible' organisations. Modern challenges to Weber's view of organisations. The impact of managerialism on health organisations.
2	Managing for Quality	Explorations of Donabedian's work (TQM) and its applications to health management. Concepts of quality, applicable in health and social care. Total Quality Management and its place in health work. Relationship between 'quality care', equity, and value for money.
3	Managing for Customers	Organisational cultures. Ideas, values, attitudes and beliefs within the client/patient oriented culture. Recognition of changing organisation with specific reference to (i) power shifts in doctors' management roles, (ii) power shift between patient and provider. Strategies to promote 'customer' services and to further develop customer orientated approaches in health care. Explorations of means of obtaining the views of the 'consumer' on satisfaction with services.
4	Planning Quality Services	Organisational analysis of the working environment to enable delivery of quality services including: environment, task, people, technology, communications, policies, socio-demography, resources, structures, cultures, power imbalance, and professionalisation.

Appendix 3 - Course on Health Behaviour and Health Education.

This course has been designed for health workers who come from a variety of cultural backgrounds. The course is in two parts. Each part is equivalent to a postgraduate level module in the Queen Margaret College scheme, that is twelve such modules make up a masters degree. Successful completion of part one is a precondition for starting the second part. It is intended that the course be available through different delivery patterns. These include an intensive two week period in the summer, with appropriate preparatory and succeeding work, the normal weekly delivery over a 12 week period, and the possibility of intensive local delivery in other countries.

Part I - Principles of Human Change. This part of the course examines the psychological basis of bringing about change in human health related behaviour through education, training and persuasion.

1	Definitions, Concepts and Issues	Health education, health promotion, health, wellness, behavioural change, education, persuasion, attitude change, models of change, research and relation to other disciplines.
2	Ethical Problems	Ethics of health education and persuasion, conflicts of interest, education versus indoctrination, advertising health; specific issues concerning: children, schools, AIDS, nutrition and mental health.
3	Theories of Health Behaviour Change	Health belief model, Reasoned action model, Attribution theory, attitude-behaviour controversy.
4	Related Theories of Change	Classical conditioning, Learning theory, consistency, Dissonance and balance, Conflict theory, attitude change, Information-integration, Elaboration theory.
5	Roles and Control	Patient-provider interactions, compliance, health behaviour, illness behaviour, control and helplessness.
6	Learning	How we learn, teachers and learners, learning as adults, teachers' roles.
7	Groups	Social learning theory, social support, interpersonal persuasion, group dynamics and communications.
8	Learning in Groups	Ways of learning together, participation, adult groups in education.
9	The Community and Change	Community organisation, social exchange theory, citizen participation, effects of customs and beliefs, action research.
10	Communications	Models of communication, Yale model, persuasive communication, information, factors in communication, proof and reasoning.
11	Social and Organisational Change	Persuasion in organisations, diffusion of innovation, marketing, social marketing, advertising, propaganda, occupational health and worksite.
12	Topics	AIDS, nutrition, mental health, smoking drugs, alcohol, cancer, pain, exercise, stress, cardiovascular system.

Part II Putting Principles of Change into Practice. This part of the course is concerned with the implications for practice of the ideas that were examined in part I. In it aspects of health promotion are examined for the help that psychological principles can be to their success.

1	Needs and Goals	Assessing needs and priorities, diagnosis of needs in behaviour, education, organisations, administration and epidemiology. Developing objectives and learning goals.
2	Evaluation	Why evaluate? The effectiveness of health education. The evaluation of: needs, processes, effects, impact, learning and teaching. Methods: surveys, questionnaires, literature reviews, focus groups and consultants.
3	Planning	Sessions, programmes, schemes of work, campaigns. Planning for different settings. PRECEDE - PROCEED.
4	Settings	Who does the health education? Specific consideration of: schools, community, occupation, health care, and local authority.
5	Client Groups	The special needs of: mothers and infants, children, adolescents, young adults, middle age, later life; life span considerations. Ethnic groups, physical disability, chronic disease, mental disability, communication disorders.
6	Facilitating Learning	Learning in groups, blocks to learning, activity and learning, techniques for facilitating learning, visual and other aids, learning in extension and at a distance.
7	Group Learning	Communications skills, discussion skills, leadership, team building.
8	Learning in the community	Learning and working with the community, working collectively, case studies of community learning, the role of the media.
9	Mass Media	Working with mass media, broadcasting, media advocacy, press releases, journalism and propaganda.
10	Presenting the Message	Visual design and presentation, visual aids, stories, role playing, puppets, drama, local resources.
11	Institutional Change	National health education plans, implementation of health education in Scotland, implementation of health education in developing countries, agencies of health education, the World Health Organisation and health education.
12	Topics	AIDS, nutrition, mental health, smoking drugs, alcohol, cancer, pain, exercise, stress, cardiovascular system.